DMHMRS 02-02
attachment I

AUTHORIZATION TO USE/SHARE
CLIENT PROTECTED HEALTH INFORMATION

1. I, _____ authorize the Department for Mental Health
(Client Name – Please Print)
and Mental Retardation Services (DMHMRS) to □ use or □ share with: _____
_____
(Individual or Agency/Organization)
the following items from my Protected Health Information: _____
_____
_____
(Specify information to be shared and dates of service)
I understand that the purpose of using or sharing this information is for: _____
_____
_____

2. I understand that I may inspect or copy my Protected Health Information prior to use or sharing.

3. I understand that I may revoke this authorization, at anytime, if requested in writing to: _____
_____, except if DMHMRS has:
(Contact Person and Address or E-Mail Address)

- taken an action based on my authorization; or
- obtained my authorization for the purpose of receiving reimbursement from a third party payer.

4. Unless previously revoked, this authorization shall expire on: _____
(Date)
after the following event has occurred or condition been met: _____
_____

5. I understand that pursuant to **KRS 304.17A-555-Patient's Right of Privacy Regarding Mental Health or Chemical Dependency-Authorized Disclosure,** my Protected Health Information used or shared under this authorization may not be shared again by the recipient of the information beyond the purpose for which authorization was given, without first obtaining my specific written consent.

I have read and understand this authorization.

_____ _____
(Individual signing authorization) *(Date signed)*

If not signed by the client, specify basis for authority to sign:
□ Parent □ Spouse □ Personal Representative
□ Other _____

_____ _____
(Staff signature) *(Date signed)*

_____
(Staff Title)